		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: <b>01</b>		(X3) DATE SURVEY COMPLETED	
			B 14/10		F	
		HAL054062	B. WING		04/0	6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KINSTON ASSISTED LIVING  2130 ROSE VISTA ROAD  KINSTON, NC 28504						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 000}	Initial Comments		{C 000}			
	This report is of a F Getchell on April 6,	follow Up Survey done by Bob 2016.				
		y revealed that all deficiencies ected, therefore a new plan of ed.				
{C 164}	Housekeeping and	Furnishings-Clean, Repaired	{C 164}			
	FURNISHINGS (a) Adult care home (1) have walls, ceil coverings kept clea (2) have no chronic (3) have furniture of	es shall: ings, and floors or floor n and in good repair;				
	kept clean and in go	vation, the Building was not cood repair, because some ts failed to function as				
	doors that are in the scuffed-up.	on April 6, 2016: ow-core closet and toilet rooms be bedrooms are very approximately 50%				
		vation, the facility failed to , and floors or floor coverings, ood repair.				
	Followup Findings of a. The carpet was s	on April 6, 2016: stained, and dirty at the				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>		(X3) DATE SURVEY COMPLETED	
					F	₹
		HAL054062 B. WING 04/06/20		6/2016		
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KINSTON	ASSISTED LIVING		E VISTA RO , NC 28504	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 164}	Continued From pa	ige 1	{C 164}			
	Central Corridor ne Central Corridor ne Central Corridor ne Staff Station Bedroom 100	ear Dining, ner just repaired. This item is completed.				
	accumulation of dir along the perimeter equipment supports NOTE: All kitchen	t, stains and grease deposits r of the floor and around				
	worn away.	e door to Bedroom 102 was collected to replace worn out				
		vation, the facility failed to clean and in good repair.				
		tstands need refinishing. approximately 50%				
{C 166}	Housekeeping-Mai	ntained Free of Hazards	{C 166}			
	FURNISHINGS (a) Adult care home (5) be maintained in orderly manner, freshazards;	06 HOUSEKEEPING AND				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: <b>01</b>		COMPLETED			
		HAL054062	B. WING		R <b>04/06/2016</b>			
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
KINSTO	KINSTON ASSISTED LIVING  2130 ROSE VISTA ROAD  KINSTON, NC 28504							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE		
{C 166}	equipment was not by not have properly Followup Findings of	et as evidenced by: vation, the Building plumbing maintained in a safe manner y working or installed parts. on April 6, 2016: of the commode to the floor	{C 166}					
{C 189}	SECTION .0300 - F 10A NCAC 13F .03 REQUIREMENTS (a) The building an mechanical, and plu care home shall be operating condition. (k) This Rule shall facilities with the ex	11 OTHER d all fire safety, electrical, umbing equipment in an adult maintained in a safe and	{C 189}					
	maintained in a safe because some build function as original?  Followup Findings of a. In the TV Room to more than normal edoor had a split in it the floor.	vation, the Building was not e and operating condition, ding components fail to y intended.  on April 6, 2016: The corridor door, requires affect to open because the s jamb allow the door the hit e door is scraping the floor						

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: <b>01</b>		(X3) DATE COMP	(X3) DATE SURVEY COMPLETED	
		HAL054062	B. WING		04/0	R 06/2016	
NAME OF	PROVIDER OR SUPPLIER		<u>I</u>	STATE, ZIP CODE	1 04/0	012010	
			SE VISTA RO				
KINSTO	N ASSISTED LIVING	KINSTO	N, NC 28504				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
{C 189}	Continued From pa	ge 3	{C 189}				
	NOTE: New door s	special ordered.					

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